STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HI JILL'S HOUSE LLC	751 E TAMARACK TRAIL BLOOMINGTON, IN 47408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00460178. Complaint IN00460178 - State deficiencies related to the allegations are cited at R0091. Survey date: June 4, 2025 Facility number: 013824 Residential Census: 25 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed June 8, 2025.	R 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective 6-13-2025. We respectfully request a desk review in lieu of a post survey Revisit	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance Based interview and record review, the facility failed to implement resident rights' policies for 1 of 3 residents reviewed for abuse. Staff did not immediately report an allegation of abuse to the administrator. (Resident B) Findings include: On 6/4/25 at 10:30 a.m., the Administrator (ADM) provided the facility reportable incidents. A reportable incident, dated 5/22/25 at 8:30 p.m., indicated CNA 2 "made a rude verbal comment to resident." During an interview on 6/4/25 at 10:45 a.m., the ADM indicated CNA 1 did not report the incident to anyone immediately.	R 0091	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was assessed and was not harmed. Regarding resident B, an assessment was completed. There were no issues identified and no evidence resident B was affected. Employee (CNA # 2) is no longer employed. Dementia specialist was scheduled and conducted an all staff in person Dementia Journey training to provide staff the	06/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	During an interview on 6/4/25 at 11:10 a.m., CNA 3 indicated during report on 5/23/25, CNA 2 had a horrible night. Every resident was up all night and was exit seeking. CNA 2 was frustrated and hoped CNA 1 was not going to report her because she made the remark she was going "to slap Resident B". During an interview on 6/4/25 at 11:40 a.m., the Wellness Director indicated the incident happened on 5/22/25. LPN 1 reported the incident to her on 5/23/25. CNA 2 worked with LPN 2 after she told CNA 1 she wanted "to slap Resident B". During an interview on 6/4/25 at 11:44 a.m., CNA 1 indicated on 5/22/25 at bedtime, CNA 2 and CNA 1 were assisting Resident B to bed. While Resident B was on the toilet in the bathroom and CNA 1 and CNA 2 were in her bedroom, CNA 2 indicated she "would like to slap her [Resident B] in the face". CNA 1 left at 10:00 p.m., and LPN 2 and CNA 2 worked the night shift. CNA 1 did not report what CNA 2 said to LPN 2 because LPN 2 did not like CNA 2; the ADM was out of town; and the Wellness Director was on vacation. She reported it to LPN 1 the next day. During an interview on 12:35 p.m., LPN 2 indicated on 5/23/25 around 2:00 p.m., CNA 1 reported to her CNA 2 wanted "to slap Resident B". At that time, she called the Wellness Director to report the incident. On 6/4/25 at 12:48 p.m., the Wellness Director provided the facility's policy, "Abuse Identification, Investigation, and Reporting, revised date 2/13, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...1. All facility employees		knowledge how to better support residents in all stages of dementia. All staff were educated on the facility abuse policy, the importance of immediately reporting any allegations of abuse, and who to report allegations of abuse to. • **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**: All staff were in-serviced by the dementia specialist during an in-person dementia training on how to maintain a calm environment while caring for dementia residents in a dementia environment. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**; All staff were educated on the facility abuse policy, the importance of immediately reporting any allegations of abuse, and who should be contacted to report any and all allegations of abuse. • **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**;	

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	will be informed, upon hire, and at least annually, thereafter of the their responsibility to report immediately to their supervisor, or to facility administration in the absence of their supervisor, actual and/or suspected incidents of resident mistreatment...physical,...verbal,...abuse..." This citation relates to Complaint IN00460178.		Facility Executive (ED) Director/designee will conduct random audits monthly for 6 months to ensure the abuse reporting policy compliance is met. The monthly compliance audits will be reviewed for six months. Quarterly audits will be completed and reviewed for an additional 3 months and as needed. • **By what date the systemic changes will be completed**. 6-13-2025	